Exhibit B

7733 Forsyth Blvd., Suite 2000
St. Louis, MO 63105
Telephone: (314) 721-2366
Facsimile: (314) 721-2377

PHYSICIAN'S APPLICATION FOR PROFESSIONAL LIABILITY POLICY

CLAIMS MADE COVERAGE

VITTORIO GUERRIERO,MD,FACS
4014 YEAGER DRIVE
GREAT LAKES,ILLINOIS 60088
773-209-3001
vguerriero@gmail.com

B.A. SAINT LOUIS UNIVERSITY 1967-1971
221 N GRAND BLVD
ST.LOUIS,MISSOURI 63108

M.D. AUTONOMOUS UNIVERSITY OF GUADALAJARA 6/71-7/76
110 GALLERY CIRCLE
SAN ANTONIO,TEXAS 78258
CITY UNIVERSITY OF NEW YORK, MT.SINAI SCHOOL OF MEDICINE
ONE GUSTAVE LEVY PLACE
NEW YORK, NY 10029

RESIDENCY IN SURGERY 7/77-7/82
COOK COUNTY HOSPITAL/UNIVERSITY OF ILLINOIS MEDICAL CENTER
1825 WEST HARRISON AVENUE
CHICAGO,ILLINOIS 60612

CERTIFICATION IN SURGERY,AMERICAN BOARD OF SURGERY- 10/16/84
RECERTIFICATION 7/1/95
RECERTIFICATION 1211/09-7/1/20

CERTIFICATION: HYPERBARIC AND UNDERSEA MEDICINE 1999
FELLOW SOCIETY OF SURGICAL ONCOLOGY
FELLOW SOCIETY OF CRITICAL CARE MEDICINE

ATTENDING SURGEON; LEVEL 1 REGIONAL TRAUMA CENTER-TEACHING SERVICE 6/88-6/92
LUTHERINE GENERAL HOSPITAL
1775 DEMPSTER STREET
PARK RIDGE,ILL 60068

CO-DIRECTOR, MIDWESTERN UNIVERSITY SCHOOL OF MEDICINE SURGICAL TRAINING PROGRAM@
EDGEWATER MEDICAL CENTER 6/96-7/00
CHICAGO,ILL 60613

PUBLICATIONS:CHICAGO MEDICINE AMA JOURNAL MEDICINE: AUGUST 1990
CLINICAL PROCEDURES REVIEW:MAY 1990

State of Illinois

Department of Financial and Professional Regulation
Division of Professional Regulation

LICENSE NO.
336.023342
036.058757

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

EXPIRES:
07/31/2014

LICENSED PHYSICIAN AND SURGEON
CONTROLLED SUBSTANCE
IIN II III IV V IIIN

VITTORIO GUERRIERO MD
6311 N LOUISE AVE
CHICAGO, IL 60646

BRENT E ADAMS
SECRETARY

JAY STEWART
DIRECTOR

The official status of this license can be verified at www.idfpr.com

5823934

Cut on Dotted Line

State of Illinois

Department of Financial and Professional Regulation
Division of Professional Regulation

LICENSE NO.
036.058757

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity as indicated below.

EXPIRES:
07/31/2014

LICENSED
PHYSICIAN AND SURGEON

VITTORIO GUERRIERO MD
4014 YEAGER DR
GREAT LAKES, IL 60088

BRENT E ADAMS
SECRETARY

JAY STEWART
DIRECTOR

The official status of this license can be verified at www.idfpr.com

5823768

Cut on Dotted Line

The NEW ENGLAND JOURNAL of MEDICINE

REVIEW CME PROGRAM

THE MASSACHUSETTS MEDICAL SOCIETY

Certifies That

VITTORIO GUERRIERO, MD

participated in the journal-based CME activity titled NEJM Review CME Program and is awarded 50 *AMA PRA Category 1 Credits™*.

PROGRAM # 367 DATE June 1, 2013

The Massachusetts Medical Society is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AAFP accreditation begins 03/01/13. Term of approval is for one-year from this date, with option for yearly renewal.

IMPORTANT INFORMATION

THIS DOCUMENT IS NOT A BINDER OR ACCEPTANCE OF INSURANCE.

Insurance coverage will not be considered until this application is completed, signed and dated. Failure to provide *complete information and attachments as requested will cause delay. Completion of this form, with or without payment* of premium, does not bind Galen Insurance Company ("Company", or "we" or "us") to issue insurance.

Completion of Application

The applicant must complete or personally supervise the completion of this application. All questions must be answered. *For questions that do not apply to your practice situation, please write "N/A" in the answer space provided.* If you do not know the answer to a particular question, please note that in the Comments Section, of this application. All questions should be answered based on the knowledge of the applicant (including his or her employees, partners, or representatives) and all affiliates, facilities, physicians, and allied professionals to be insured under the policy, if issued. All questions should be answered based on the information applicable to and regarding the applicant and all affiliates, facilities, physicians, and allied professionals for whom coverage is being sought.

Please note the additional information (and related checklist) required and outlined at the end of this application. Make certain that all required information and attachments are provided in order to assist us in processing this application promptly and efficiently.

If an explanation is required for any answer, please use the Comments Section, of this application to provide the explanation. If additional space is necessary, attach separate, additional pages to this application.

If additional forms are required or if a question arises about the application process, please call the Company at: 314-721-2366.

This document is an application for a claims-made policy of professional liability insurance. If issued, coverage under the policy is limited to liability for those claims that: (a) arise from incidents or events that happen while coverage under the policy is in force and that involve a named insured's professional services; and (b) are first made against a named insured and are reported to the Company during the policy period, including any extended reporting period, or during any optional extended reporting period provided through an endorsement.

INSURANCE COVERAGE IS SUBJECT TO UNDERWRITING APPROVAL AND FULL PAYMENT OF THE PREMIUM. NO COVERAGE EXISTS UNTIL THE PREMIUM IS FULLY PAID AS AGREED AND A DECLARATION PAGE, TOGETHER WITH ANY ENDORSEMENTS THAT MAY APPLY, HAS BEEN ISSUED TO THE POLICYHOLDER.

Galen Insurance Company
7733 Forsyth Blvd., Suite 2000
St. Louis, MO 63105
Telephone: (314) 721-2366
Facsimile: (314) 721-2377

PHYSICIAN APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

Please answer all questions fully and completely. If you do not have enough space to provide a complete answer, please use Part VII, the Comments Section, of this application, or attach separate page(s), identifying the question and providing the additional information necessary for a complete answer. PLEASE TYPE OR PRINT LEGIBLY.

Personal Information

1. Full Name: Vittorio Guerriero, M.D.
   Include all names by which you have been known, and dates during which the name was used.
2. Date of Birth: 01/15/1949 3. SS# 343-44-3834 4. ☒ Male ☐ Female
5. Home Address: _____ 6. ~~Home~~ Cell Phone: 773-209-3001
7. Email address: vguerriero@gmail.com 8. M.D. or D.O or other M.D.
9. Are you a U.S. Citizen? ☐ Yes ☐ No; If no, please describe your current status, including your intentions regarding future citizenship: _____

If you answer yes to the any of the following questions, please provide complete details on the Comments Page.

10. Have you ever had your membership in any professional society or association refused, suspended, revoked or ever received any criticism or reprimand from any professional society? ☐ Yes ☒ No
11. Have you ever been investigated, disciplined, censured, or reprimanded by a professional society or board or a licensing board? ☒ Yes ☐ No
12. Are there any restrictions on your current hospital privileges? ☐ Yes ☒ No
13. Has any hospital or other institution ever restricted, reduced, refused, or suspended your privileges or invoked probation? ☐ Yes ☒ No
14. Have you ever been under any hospital disciplinary observation, preceptorship, or sponsorship? ☐ Yes ☒ No
15. Have you ever voluntarily surrendered or had your license to prescribe or dispense narcotics refused, suspended, limited in any way, or revoked? ☐ Yes ☒ No
16. Are you now on probationary status? ☐ Yes ☒ No
17. Have you ever been investigated, charged with, or convicted of a violation of a federal, state, or local law other than routine traffic offenses? ☐ Yes ☒ No
18. Have you ever voluntarily surrendered or had any state license to practice medicine refused, restricted, suspended, or revoked? ☐ Yes ☒ No
19. Have you ever been treated for alcoholism, mental illness, or narcotics addiction? ☐ Yes ☒ No
20. Have you ever used any intoxicant, narcotic, or other psycho-active drug to the extent that it either has interfered with your ability to perform professional services or caused you to seek medical advice or treatment? ☐ Yes ☒ No

21. Do you currently have any health problem, illness, or physical condition that impairs or could impair your ability to practice medicine? ☐ Yes ☐ No
If yes, please submit a letter from your treating physician addressing your state of health and whether any conditions exist that could adversely affect the practice of medicine by you.

22. Has any physician, professional, or patient ever filed a complaint against you with any professional society, licensing board, board of examiners, or similar organization? ☐ Yes ☐ No
If yes, please provide copies of complaint and disposition documents.

Policy Information:

23. What would the effective date of your policy be? 12/16/2013

24. If seeking prior acts coverage, what would your retroactive date be? 12/16/2011

25. Will you be the policyholder, or a named insured on a group policy?
☒ Policyholder
☐ Named Insured/Member of Group

If a named insured/member of a group, what is the group name? _____

26. Separate limits requested for: Named Insured(s): _____
☐ $1,000,000 Per Claim, $3,000,000 Annual Aggregate
☐ Other: $_____ Per Claim, $_____ Annual Aggregate

27. Shared limits requested for: Named Insured(s): _____
☐ $1,000,000 Per Claim, $3,000,000 Annual Aggregate
☐ Other: $_____ Per Claim, $_____ Annual Aggregate

28. Deductible requested:
☐ Zero ☐ $5,000
☐ $1,000 ☐ $10,000
☐ $2,500 ☐ Other: $_____

Educational Information and Licenses/Certification

29. Medical School: Autonomous University of Guadalajara Dates: From 1971 To 1976
City: _____ State: _____ Country: _____ Degree: M.D.

30. Internship - Facility Name: City University of New York/ Mt. Sinai School of Medicine Dates: From 1976 To 1977
City: New York State: NY Country: U.S. Specialty: _____

31. Residency - Facility Name: Cook County Hospital Dates: From 1977 To 1982
City: Chicago State: IL Country: U.S. Specialty: Surgery
Type of Residency: _____ Completed: ☒ Yes ☐ No

32. Other Training (fellowships, military service, etc.):
Name, location, and type: _____ Dates: From _____ To _____
Name, location, and type: _____ Dates: From _____ To _____

33. If you are a foreign medical school graduate, are you certified by the Education Commission for Foreign Medical School Graduates (ECFMG)? ☐ Yes ☒ No
If licensed by ECFMG, identify states or countries, license number, and date: _____

34. Do you hold the foreign equivalent of board certificates? ☐ Yes ☒ No
If no, please explain _____

35. List the states in which you are currently licensed:
State: Illinois License No.: 036-058757 Active? ☒ Yes ☐ No
State: _____ License No.: _____ Active? ☐ Yes ☐ No

36. DEA License Number: AG 9058050 Dates: From _____ To _____

37. Identify all medical and professional societies to which you belong: _____

38. Do you have board certification recognized by the American Board of Medical Specialists or the American Osteopathic Association? ☒ Yes ☐ No
If yes, identify: Specialty Surgery Subspecialty _____

If not board certified, why:

Please identify the date you plan to become board certified: _____

39. Have you ever been refused board certification? ☐ Yes ☒ No
If yes, please provide complete details in Part VII of this application.

40. What percentage of your practice is devoted to your specialty and subspecialty?
Specialty: 100 % (General Surgery) Subspecialty: _____ %

Practice Information

41. Practice Name: _____

42. Practice Address: 2200 State St. Lawrenceville, IL 62439

43. Practice Phone, Fax and Contact Person: P: 618-943-3100 F: _____ Contact: _____

44. Are you full or part time? Part Time If part time, how many annual hours do you work? <20 hours

45. If you perform surgery, please list the five procedures you perform most often, the approximate % of your practice these procedures represent and how long you have performed these procedures:

Procedure	%	Years

46. Do you perform any procedures which require specialized training (e.g. bariatrics)? ☐ Yes ☒ No
If yes, please list these procedures in the comments section.

47. Do you provide care for minors? ☐ Yes ☒ No
If yes, how much of your practice consists of the treatment of minors? _____

48. Do you practice in states other than Missouri? ☒ Yes ☐ No
If yes, please list states and the percentage of your time practicing there:

State	County	% of practice
IL	Lawrence	100

49. Are you entering private practice for the first time? ☐ Yes ☒ No

50. List all locations (names and addresses) where you have practiced since residency
Present location: Lawrenceville, IL Dates: From 9/6/13 To Present
Prior location: Chicago, IL Dates: From 1982 To 6/2013
Prior location: _____ Dates: From _____ To _____

51. Please explain any gaps in your training or practice, if not explained in your curriculum vitae: _____

52. How many category 1 credit hours of continuing medical education do you attend annually? 50

53. Do you hold any positions as director or trustee of any licensed hospital or medical institution? ☐ Yes ☒ No
If yes, please provide complete details in Part VII of this application.

54. Do you perform any medical legal evaluations? ☐ Yes ☒ No
If yes, for whom? _____
What percentage of your practice does this entail? _____%

55. Do you have any teaching responsibilities? ☐ Yes ☒ No
If yes, identity name and location of institution: _____
Does this institution provide you insurance coverage for your supervision of residents? ☐ Yes ☐ No
What percentage of your weekly time is spent supervising residents? _____%
If no insurance has been provided by this institution for your services, please attach a copy of your contract or letter of agreement for our review.

56. Do you have any medical director responsibilities? ☐ Yes ☒ No
If yes, identify name and location of entity: _____
Does the entity provide you with insurance for your administrative responsibilities? ☐ Yes ☐ No
Does the entity provide you with insurance for your direct patient care? ☐ Yes ☐ No
If insurance is not fully provided by the entity, please attach a copy of your contract or letter of agreement.

57. Do you employ or supervise any physicians or allied professionals? ☐ Yes ☒ No
If yes, specify the number, role and type of physician or allied professional.

Number:	Employ or Supervise:	Type:

58. Will you be performing activities that will be covered by another professional liability policy? ☐ Yes ☒ No
If yes, please provide complete details (include name and address of entity) in Part VII of this application and provide proof of coverage.

59. Do you treat prison or jail inmates? ☐ Yes ☑ No
If yes, please provide complete details in Part VII of this application.

60. Do you participate in quality assurance, peer or utilization review activities for others? ☐ Yes ☒ No

61. Do you have management responsibilities at a facility or organization not owned by you? ☐ Yes ☒ No

62. If yes to Question 61, is your malpractice insurance coverage provided by the entity? ☐ Yes ☐ No
If yes, please provide complete details in Part VII of this application, including the name and location of entity, your title, and responsibilities and duties.
If insurance is not fully provided by the entity, please attach a copy of your contract or letter of agreement.

63. Have your practice specialties or procedures changed in the past five (5) years? ☐ Yes ☒ No
If yes, please provide complete details in Part VII of this application of how the specialties or procedures have changed and give the dates of changes.

64. Please complete the following information regarding the patient volume of your practice (weekly average):
Number of patients seen by you in the office: 20 per week
Number of patients seen by you in the hospital: 2 per week
Number of patients seen only by paramedical personnel employed by you: 0 per week
Walk-in patients 0 per week
Total 22 per week

65. Please indicate average number of hours per week that you spend in the following:
Office practice: < 15 hours Emergency room: 0 hours
Hospital practice: < 5 hours On-call: 0 hours

66. Do you practice in any other capacity not already identified thus far in this application? ☐ Yes ☒ No
If yes, please provide complete details in Part VII of this application.

67. Do you perform any surgery in your office? ☐ Yes ☒ No
If yes, describe and include type of anesthesia (local, sedation, general):

68. Do you perform surgery in other non-hospital facilities? ☒ Yes ☐ No
If yes, name the facilities and type of surgical procedures performed. Grand Ave Surgicenter
Same day surgical procedures ie. hernia biopsy soft tissue etc

69. In the course of surgery described above, is general anesthesia administered?
by you? ☐ Yes ☒ No
by others? ☒ Yes ☐ No

70. Do you personally provide pre-operative exams and post-operative care for all surgical patients? ☒ Yes ☐ No
If no, please explain:

71. PLEASE REVIEW CAREFULLY AND CHECK AND COMPLETE ALL ITEMS THAT APPLY TO YOUR PRACTICE, EVEN IF THE PROCEDURES ARE OUTSIDE YOUR SPECIALTY OR DUPLICATIVE. For any item marked with an asterisk, please provide proof of training and certificates of completion.

- Abdominoplasty
- Abortions – First Trimester; # Per Year:
- Abortions – Therapeutic
- Acupuncture, anesthesia
- Acupuncture, therapy
- Acupuncture, other
- Amniocentesis
- Anesthesia – surgical
- Anesthesia – caudal
- Anesthesia – epidural
- Anesthesia - general
- Anesthesia – Local
- Angiography – lymph
- Angiography, other
- Angioplasty
- Appendectomy; # Per Year: 3
- Arteriography
- Assisting in Surgery – own patients
- Assisting in Surgery – Patients of Others
- Autologous Fat Injection – Breast
- Autologous Fat Injection – Penis
- Bartholin cyst or abscess, I&D
- Biopsy, Breast, cyst aspiration
- Biopsy, Breast, excisional
- Biopsy, Breast, incisional
- Biopsy, Breast needle
- Biopsy, Cervical
- Biopsy, Heart
- Biopsy, Liver
- Biopsy, Skin
- Biopsy, Other SKIN
- Blepharoplasty – Cosmetic
- Blepharoplasty - Functional

Blocks - Caudal Epidural
Blocks - Celiac Plexus
Blocks - Cervical
Blocks - Cervical Epidural
Blocks - Differential Spinal
Blocks - Facet Injection, Lumbar only, under Fluoroscopy
Blocks - Facet Injection, other than Lumbar, under Fluoroscopy
Blocks - Facet Joint Block
Blocks - Lumbar
Blocks - Lumbar Epidural
Blocks - Lumbar Sympathetic
Blocks - Motor Point and Peripheral Nerve
Blocks - Peripheral Nerve
Blocks - Retrobulbar
Blocks – Spine*
Blocks - Spinal Nerve
Blocks – Non-spine*
Blocks - Stellate Ganglion
Blocks - Subarachnoid Block
Blocks - Supraclavicular
Blocks - Suprascapular Nerve
Blocks - Sympathetic Nerve
Blocks - Thoracic
Blocks - Trigger Point Pain Injection
Bone Marrow Aspiration
Bone marrow biopsy
*Botox Injections - Cosmetic**
Botox Injections – Pain Management*
Botox Injections – Other*
Breast Augmentation or Reduction
Browplasty/Brow Lift
Buccal Fat Extraction
Cardiac Bypass Pump
Cardiac Catheterization, Left Heart
Cardiac Catheterization – Right Heart (Swan Ganz)
Cataract Surgery, lens implant
Cataract Surgery, no lens implant
Cesearean section
Cervical Discograms
Cervical Disc Nucleoplasty
Chalazion Excision from Eyelids
Chelation Therapy
Chemical Peel
Chemical face peel with phenol*
Chemotherapy
Circumcisions – Adult
Circumcisions – Pediatric
Closed reductions of simple fractures; # Per Year:_____
Closed reductions - other; # Per Year:_____
Collagen Injection
Colposcopy
Cone biopsy
Cordotomies
Corneal Transplant
Cosmetic, Other - Identify all procedures not listed on separate sheet
Cosmetic, Ear Surgery
Cosmetic, Major Surgery
Cryanalgesia
Cryosurgery, benign or pre-malignant dermatological lesions
Cryotherapy
Cystoscopy
Dermabrasion/ Chemabrasion
Dermatology
Dermatology: Acne surgery
Dermatology: Collagen Injection
Dermatology: Liposuction
Dermatology: MOHS surgery
Dilation and Curettage # Per Year:_____
Digital Subtraction Angiography
Discograms
Dorsal Column Stimulator Implant or Reprogram
Electric Shock Therapy
Electrosurgical Procedures
Endometrial Aspiration
Endometrial Biopsy
Endoscopy – Bronchoscopy
Endoscopy, Colonoscopy
Endoscopy, Esphagoscopy
Endoscopy, Gastroscopy
Endoscopy, Pelvioscopy
Endoscopy, Protoscopy
Endoscopy, Sigmoidoscopy, flexible to 65cm
Endoscopy, Signoidoscopy, flexible to above 65cm
Ensoscopy, Sigmoidoscopy, rigid
Endoscopy, ERCP
Endoscopy, Other: _____
Enucleation
Epidural or Spinal Catheters
Epikeratophakia (KME)
EPS (provocable electrophysiologic tests)
Excisions, Simple
Excisions of skin lesion(s) with graft or flap repair
Fertility Counseling/Artificial Insemination
Fibrel Injection
Face Lifts
Fat Transplantation
FDA Approved Experiments
Fracture Reduction – Closed – Simple
Fracture Reduction – Closed – Other than Simple
Fracture Reduction – Open
Fluroscopy
Gastric Balloon
Hair Transplant - Human Hair
Hair Transplant - Synthetic Hair Fibers
Hand Surgery
Hemorrhoidectomies; # Per Year:_____
Hemorrhoidectomy – Ligation Only
Hemorrhoidectomy – Other than Ligation
Histories and Physicals
Home Services
Human Growth Hormone
Hypnosis
Hysterectomy – Abdominal
Hysterectomy - Other
In Vitro Fertilization (IVF)
Independent Medical Evaluations
Injections for chymopapain or those containing sclerosing agents
Intraop EEG/EP Monitor
Intravascular absolute alcohol embolization
Intra-Articular Block (Joint *Injections*)
Intradiscal Electrothermal Therapy
Intravenous Regional Anesthesia
IUD Insertion or Diaphragm Fitting
Jejuno-ileal bypass or gastric bubble procedures for treatment of morbid obesity
Joint Injection (Intra-articular Block)
Keratotomy
Laceration Repairs
Laparoscopy
Laser Hair Removal
Laser Skin Resurfacing – Face Only
Laser Skin Resurfacing – Other
Laser Surgery
LASIK*
Leeps/Leetz Procedure
Lens implant, no cataract surgery
Lid Repair
Lumbar Discograms
Lumbar Disc Nucleoplasty
Lumpectomy-Superficial Skin Lesion
Lumpectomy – Other
Mammoplasty
Management of Ectopic Pregnancy
Manipulation or Massage
Manipulation Under Anesthesia
Mastectomy
Mesotherapy
Myelography
Myofascial Trigger Point Injections
Myringotomy
Needle Biopsy – including lung and prostrate
Needle Biopsy – including liver, kidney, or bone marrow biopsy
Nerve Root Injections
Non-FDA Approved Experiments or Studies
Nuclear Medicine
Obstetrical Deliveries – Birthing Center; # per YR:_____
Obstetrical Deliveries – Birthing Center; # per YR:_____
Obstetrical Deliveries – Home or Other; # per YR:_____
Office Gynecology
Ophthalmic plastic surgery, cosmetic
Orthopedic: Non-surgical care ONLY
Otoplasty
Pacemaker implant-temporary
Pacemaker implant, permanent
Pain Control or Management – Medication Only
Pap Smears
Paracentisis
Pars plana vitrectomy
Pelvic Examination
Percutaneous Discectomy
Percutaneous Transluminal Coronary Angioplasty
Percutaneous Valvuloplasty
Peripheral Nerve Stimulation
Photorefractive Keratotomy (PRK)
Phototherapeutic Keratotomy (PTK)
Physical Therapy

PHY-PLP

- Prenatal Exam – Diagnose Only (refer to others)
- Prenatal Exam – 1st Trimester
- Prenatal Exam – 2nd Trimester
- Prenatal Exam – 3rd Trimester
- Pneumoencephalography
- Prolotherapy
- Prolotherapy with Phenol
- Prolotherapy without Phenol
- Radio Frequency Nerve Ablation
- Radial Keratotomy
- Radiation Therapy
- Radioplaque dye injections into blood vessels, lymphatic, sinus tracts and fistulae
- Rapid Detoxification
- Refractive keratoplasty, other
- Removal of moles and warts
- Renal Dialysis
- Retinal detachment surgery
- Retrobulbar mass
- Rhinoplasty - Cosmetic
- Rhinoplasty – Functional Only
- Scar Revisions or Repair
- Scalp Reductions
- Sclerotherapy (the injection of sclerosing agents) into the vertebral column
- Sex Change Surgery
- *Silicone Injection*
- Silicone Implant
- Sperm Banks for other than storage for insemination of your own patients
- Sphenopalatine Lesioning
- Spinal Infusion Pump – Implants
- Spinal Infusion Implants or Removal
- Spinal Infusion Pumps Refilling or Reprogramming
- *Spinal Stimulation Implants*
- Spinal Stimulation Programming
- Spinal Surgery
- Steroid injections for bursitis
- Suction Assisted Lipectomy (SAL) – Hips/Buttocks/Abdomens/Thighs*
- Suction Assisted Lipectomy (SAL) – Full Body*
- Suction Assisted Lipectomy (SAL) – limited to Head/Neck*
- Suction Assisted Lipectomy (SAL) – Eye Area*
- Suction Assisted Lipectomy (SAL) – Arms
- Surgery
- Surgery: Amputation (major)
- Surgery: Appendectomy
- Surgery: Bariatric
- Surgery: Biliary
- Surgery: Bunionectomy
- Surgery: Cardiac
- Surgery: Carpal tunnel release; # Per Year:_____
- Surgery: Closed Reduction; # Per Year:_____
- Surgery: Colon
- Surgery: Excisions of superficial lesions; # Per Year: 30
- Surgery: Ganglionectomy; # Per Year:_____
- Surgery: Hand ONLY
- Surgery: Hand - Arthrocentesis
- Surgery: Hand - Aspiration or Injection of Fingers, Wrist or Shoulder
- Surgery: Hand - Bone, tendon, nerve graft
- Surgery: Hand - Capsulectomy for joint stabilization
- Surgery: Hand - Capsulectomy or capsuloplasty for contracture
- Surgery: Hand - Complex Soft Tissue Repair; # Per Year:_____
- Surgery: Hand - Debridement/excision of nails not including the nail matrix or complicated nail bed reconstruction
- Surgery: Hand - Foreign body removal to include wire pin, screw, plate
- Surgery: Hand - Injection of tendon sheath, ligament or trigger point
- Surgery: Hand - Joint Replacement
- Surgery: Hand - Local flaps not including distant
- Surgery: Hand - Pedicle, free, etc.
- Surgery: Hand - Percutaneous or Internal Fixation
- Surgery: Hand - Scar revision
- Surgery: Hand - Skin graft
- Surgery: Hand - Synovectomy, tenosynovectomy
- Surgery: Hand - Tenovaginotomy for "Trigger" Finger; # Per Year:_____
- Surgery: Hand - Thenar Muscle Release for Contracture
- Surgery: Hand and Others
- Surgery: Herniorrhaphy
- Surgery: Herniorrhaphy (only inguinal, femoral epigastric or umbilical)
- Surgery: Implants - Type:_____
- Surgery: Incision of boil or superficial abscess
- Surgery: Injection treatment of varicose veins
- Surgery: Intestinal resection
- Surgery: Joint Replacement
- Surgery: Laminectomy
- Surgery: Laparoscopic Cholecystectomy
- Surgery: Lipectomy
- Surgery: Major Assist Only
- Surgery: Major
- Surgery: Mastectomy
- Surgery: Morton's neuroma; # Per Year:_____
- Surgery: Neurological – Other Major Procedures
- Surgery: Open Reduction
- *Surgery: Organ transplant*
- Surgery: Other Major Procedures
- Surgery: Percutaneous or Internal Fixation
- Surgery: Plastic, Cosmetic
- Surgery: Plastic, Reconstructive
- Surgery: Primary Extensor Tendon Repair (foot or hand); # Per Year:_____
- Surgery: Prostatectomy
- Surgery: Spinal Column
- Surgery: Submucous Nasal Resection
- Surgery: Thoracic
- Surgery: Total Joint Replacement
- Surgery: Thyroidectomy
- Surgery: Urological
- Surgery: Vascular
- Surgery: Weight Control
- Surgery: Weight Control, Intestinal Bypass
- Surgery: Weight Control, Other Abdominal Surgery
- Surgery: Suture Skin and Superficial Facia
- Surgery: Tenotomy of Toes; # Per Year:_____
- Surgery: Tonsillectomy or Adenoidectomy
- Surgery: Transplants - Type:_____
- Surgery: Other:_____
- TAH/BSO
- Tattoo, tattoo removal or repair, cosmetic tattooing
- T & A's; # Per Year:_____
- Tendon Repair
- Therapeutic Radiology
- Thoracic Sympathectomies
- Trigeminal Lesioning
- Tubal ligation, post partum
- Tubal ligation, other
- Ultrasound – For Obstetrics
- Ultrasound - Other
- Use of chorionic gonadotropin in *treatment of obesity*
- Use of Laetrile (Amygdalin or Vitamin B-17)
- Vaginal delivery
- Vasectomy
- Vein Stripping*
- Vertebroplasty
- Weight control treatment - diet only
- Weight control treatment, non surgical
- Weight control drugs dispensing, (as opposed to prescribe)
- X-ray interpretation of chest, extremity, rib and clavicle films
- Other non-surgical:_____
- Wound Débridement

Insurance History:

73. If you are seeking prior acts coverage and will be the policyholder complete the following chart for all of your professional liability insurers during the prior acts coverage period. Begin with your most recent professional liability insurer.

Claims- Made or Occurrence	Year (s)	Insurance Carrier	Policy Number	Coverage Period From/To:	Liability Limits Per Claim/Aggregate
CM		FPIC		12/14/12 - 12/14/13	1m/3m
CM		FPIC		12/14/11 - 12/14/12	1m/3m
CM		Medicos		6/8/08 - 6/8/10	
CM		PLICA		6/8/06 - 6/8/07	
CM		Essex		3/8/01 - 6/8/06	

74. Have you ever been notified of your involvement in a malpractice claim, suit, or incident, either directly or indirectly? ..... ☒ Yes ☐ No
If yes, please complete Form A attached for each claim, suit or incident and submit the completed Form A with this supplemental application.
If yes, were each of those claims, suits, or incidents reported to your malpractice insurer(s)? ☐ Yes ☐ No

75. Are there any claims or suits threatened or pending against you or has there been any circumstance, occurrence, incident, or accident that is likely to give rise to a claim or suit that has not been reported to your current or prior insurers? ..... ☐ Yes ☒ No

76. Has any incident, claim, or suit involving you been reported to another insurer by any of your current or former employees, partners, or associates on their own behalf, but not reported on your behalf? ..... ☐ Yes ☒ No

NOTE: All incidents identified in response to Questions 75-77 should be reported to your current insurer – but doing so does not necessarily eliminate the need for tail coverage. If your current insurance is written on a claims-made form, it is necessary to purchase tail coverage from your present insurer or nose coverage (prior acts coverage) from the Company to reduce the possibility of having a gap in coverage.

77. Has your prior insurance coverage ever included coverage for another person not already identified as part of this application? ..... ☐ Yes ☒ No
If yes, please explain on a separate sheet and attach a copy of any endorsement(s) providing coverage for such individual (including locum tenens) or an entity. Each is subject to separate underwriting consideration.

INFORMATION REQUIRED - CHECKLIST

Please submit the following, along with the other information requested in this application:

- ☐ Medical licenses.
- ☐ Curriculum vitae.
- ☐ Most recent certificates for completion (attendance) for continuing medical education programs.
- ☐ Authorization for release of information (page 12 of the application) signed by you.
- ☐ Completed Form A (page 13 of the application) for all claims, suits and incidents in the past 10 years. (If no claims, mark "0 claims" and sign)

***Supplemental applications are required for physicians practicing Anesthesiology, Bariatric Surgery, and Obstetrics as well as Locum Tenens.**

COMMENTS SECTION (use additional sheets as necessary)

Page Number	Question Number	Comment

Galen Insurance Company

Form A - Claim/Incident Report

Please complete for each suit, claim, or incident for which you responded yes in Questions 74-76 of the application. Please provide complete details in order to allow proper evaluation without the need for additional information. Attach copies of patient's charts, operative notes, or other documents as appropriate.

1. Name of patient:_____ Age:_____ Sex:_____

2. Type: ☐ Incident ☐ Request for records ☐ Demand for money or services ☐ Suit.

3. Date of incident:_____ Date Notified:_____ Location of incident:_____

4. Date Reported to Insurer:_____ Name of Insurer:_____

5. Allegation:_____

6. Condition/diagnosis at time of incident:_____

7. Dates/description of treatment rendered:_____

8. Other physicians, professionals or entities involved:_____

9. Disposition of claim:
   - ☐ Suit threatened, no action taken
   - ☐ Suit filed but dropped by claimant
   - ☐ Closed without payment
   - ☐ Summary judgment in your favor
   - ☐ Court outcome in your favor - ☐ jury verdict ☐ directed verdict
   - ☐ Court outcome in favor of plaintiff - ☐ jury verdict ☐ directed verdict, $_____ verdict amount
   - ☐ Settled out of court
     - Date Claim Paid:_____
     - Amount paid on your behalf: $_____
     - Did you wish settlement of the claim? ☐ Yes ☐ No
   - ☐ Open - Status Pending: ☐ awaiting mediation/arbitration or ☐ awaiting court action
     - Reserve Amount: $_____

I understand this information becomes a part of my application for professional liability insurance.

Print name:_____ Date: 12 2 4 13

Signature: [signature]

FORM B – PROFESSIONAL LIABILITY ACTIONS

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

Applicant Name: Guerriero (Last) Vittorio (First) (MI)

A. Plaintiff's Name: Pena (Last) Shirley (First) (MI)

If court case, Case Name & Case Number: Shirley Pena v. Vittorio Guerriero, M.D., Case No. 08 L 12109

B. Your Involvement in the Care (Attending, Consulting, Etc.): Attending

C. Your Status in the Case (Sole Defendant, Co-Defendant, Ownership Interest in Provider Practice Name in Suit, Etc.): Sole Defendant

D. Allegations, including Patient Outcome, if Available: Ms. Pena alleged a failure to perform an adequate work up prior to Roux-en-Y surgery to treat her recurrent bile reflux. She claimed the Roux-en-Y limb was not long enough and that her symptoms returned, requiring an additional surgery to revise the Roux-en-Y limb length. She has no current GI complaints.

E. Date of Incident (mm/yy): 09/07

F. Date Filed (mm/yy): 10/08

G. Date Case Closed (mm/yy): 02/12

Resolution Case: ☐ Dismissed ☒ Settlement out of Court ☐ Judgment ☐ Pending ☐ Arbitration ☐ Mediation ☐ Other

H. Amount Paid on Your Behalf (if any): $ 60,000

I. Professional Liability Insurer Name (if one was involved): Medicus Insurance Company

J. Insurer Telephone Number: (512-467-2800

K. Policy Number: IL 180000969.001-1

L. Insurer Address (Street, City, State, Zip Code): 6034 West Courtyard Drive, Suite 310, Austin, Texas 78730

Signature: V Guerriero MD Date: 12/24/13

FORM B – PROFESSIONAL LIABILITY ACTIONS

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

Applicant Name: Guerriero (Last) Vittorio (First) (MI)

A. Plaintiff's Name: Mironov (Last) Leonid (First) (MI)

If court case, Case Name & Case Number: Leonid Mironov v. Vittorio Guerriero, M.D. Case No. 09 L 3205

B. Your Involvement in the Care (Attending, Consulting, Etc.): Attending

C. Your Status in the Case (Sole Defendant, Co-Defendant, Ownership Interest in Provider Practice Name in Suit, Etc.): Sole Defendant

D. Allegations, including Patient Outcome, if Available: Mr. Mironov alleged failure to perform an adequate examination of his left lower extremity before performing a segmental vein stripping procedure to treat post phlebitic syndrome and venous stasis ulcer. He required a debridement procedure after he presented to the ER with gangrene 3 weeks later, after which he ultimately required a left below the knee amputation. He currently ambulates with a prosthetic.

E. Date of Incident (mm/yy): 08/08 F. Date Filed (mm/yy): 03/09

G. Date Case Closed (mm/yy): 02/12

Resolution Case: ☐ Dismissed ☒ Settlement out of Court ☐ Judgment ☐ Pending ☐ Arbitration ☐ Mediation ☐ Other

H. Amount Paid on Your Behalf (if any): $ 650,000

I. Professional Liability Insurer Name (if one was involved): Medicus Insurance Company

J. Insurer Telephone Number: (512-467-2800 K. Policy Number: IL 180000969.001-1

L. Insurer Address (Street, City, State, Zip Code): 6034 West Courtyard Drive, Suite 310, Austin, Texas 78730

Signature: V Guerriero MD Date: 12/24/13

THIS APPLICATION WILL BE ATTACHED TO AND BECOME A PART OF THE POLICY.

The undersigned applicant hereby represents to Galen Insurance Company (the "Company") that all statements and explanations contained in this application and all attachments are true, complete and accurate, and that the applicant has not withheld any information that is reasonably likely to influence the judgment of the Company in considering this application for professional liability insurance. The applicant agrees to notify the Company of any change in the information contained in this application or any attachment if the change occurs while this application is under review or after coverage begins, if a policy is issued. The applicant further agrees to be bound by, and subject to, the underwriting guidelines, policies, and procedures of the Company.

The applicant acknowledges that he or she is responsible for payment of all unpaid premiums regardless of whether anyone has agreed to pay premiums on his or her behalf.

The applicant understands and acknowledges that upon acceptance of this application by the Company, this application will become a part of the policy and operate as part of a contract between the applicant and the Company. The applicant also understands and acknowledges that any misstatement or omission by the applicant or anyone for whom coverage is being sought, or any failure by the applicant or anyone for whom coverage is being sought to cooperate fully with Company will, in the discretion of the Company, result in the exclusion of a related claim from coverage under the policy and that under such circumstances the Company will not pay damages or claim expenses nor provide a defense to such a claim. In addition, such misstatements or failure to cooperate may result in cancellation of the policy.

The applicant hereby affirms that he or she has completed the required reporting of incidents and claims to the applicant's current insurer.

I understand this information becomes a part of my application for professional liability insurance.

AUTHORIZATION FOR RELEASE OF INFORMATION

The undersigned hereby authorizes Galen Insurance Company and its affiliates, agents, and representatives (the "Company") to make inquiries, investigate, and consult with all persons, places of employment, educational institutions, malpractice insurance carriers, state licensing boards, or other similar government and non-governmental entities or persons who may have information bearing on the undersigned's moral, ethical, and professional reputation and qualifications, training, and competence to carry out the practice of medicine. The undersigned authorizes release of such information and copies of related records and documents to the Company.

The undersigned releases from liability and holds harmless all persons who provide information to the Company in good faith and without malice in response to such investigations and inquiries, and releases from liability and holds harmless the Company for all information disclosed by the Company in good faith and without malice in making such investigations and inquiries.

The undersigned agrees that a photocopy or facsimile of this authorization will serve as if it were the original.

INSURANCE COVERAGE IS SUBJECT TO UNDERWRITING APPROVAL AND FULL PAYMENT OF THE PREMIUM. NO COVERAGE EXISTS UNTIL THE PREMIUM IS FULLY PAID AND RECEIVED AND A DECLARATION PAGE, TOGETHER WITH ANY ENDORSEMENTS THAT MAY APPLY, HAS BEEN ISSUED TO THE POLICYHOLDER.

Print Name of Applicant: Vittorio Guerriero, MD

Signature Guerriero MD Date 122413